

ANZUPGO

PRIOR AUTHORIZATION

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis:

Chronic hand eczema (CHE)

Other (ICD code plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- Is the patient currently treated with the requested agent? Yes No
- Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify contraindication(s): _____
- Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
If no, is there support for using the requested agent for the patient’s age for the requested indication? Yes No
If yes, please provide supporting information: _____
- Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? Yes No
If yes, is there support for therapy with a higher dose for the requested indication? Yes No
If yes, please provide supporting information: _____
If no, is there support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit? Yes No
If yes, please provide supporting information: _____
- Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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6. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., dermatologist, allergist, immunologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
7. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibinqo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Enbrel (etanercept), Entyvio (vedolizumab), Fasenna (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Imuldosa (ustekinumab-srlf), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Nemludio (nemolizumab-ilito), Nucala (mepolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenzia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended-release), Otulfi (ustekinumab-aaaz), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Stelara (ustekinumab), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]? Yes No
- If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? Yes No
- If no, is there support for the use of combination therapy? **Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required.** Yes No

For Chronic Hand Eczema (CHE) requests:

8. Does the patient have hand eczema that has been present for greater than 3 months OR has returned at least twice in a year after its initial presentation and subsequent clearance? Yes No
9. Is the patient's disease severity moderate-to-severe? Yes No
10. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of CHE after at least a 4-week duration of therapy? Yes No
- If yes, please specify agent: _____
- If no, does the patient have an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of CHE? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids used in the treatment of CHE? Yes No
- If yes, please specify FDA labeled contraindication: _____
11. Is the patient currently treated with topical emollients/moisturizers AND is practicing good skin care? Yes No
- If yes, will the patient continue the use of topical emollients/moisturizers and good skin care practices in combination with the requested agent? Yes No

For renewal requests:

12. Has the patient had clinical benefit with the requested agent? Yes No
13. Will the patient continue standard maintenance therapies (e.g., topical emollients/moisturizers, good skin care practices) in combination with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

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